UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

vs.

D-1 DR. RAJENDRA BOTHRA
D-3 DR. GANIU EDU
D-4 DR. DAVID LEWIS
D-5 DR. CHRISTOPHER RUSSO,

Case No. 18-20800
Hon. Stephen J. Murphy, III

Defendants.
_____/

JURY TRIAL EXCERPT: VOLUME 14

BEFORE THE HONORABLE STEPHEN J. MURPHY, III
United States District Judge
Theodore Levin United States Courthouse
231 West Lafayette Boulevard
Detroit, Michigan 48226
Monday, June 6, 2022

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(Appearances continued next page)

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Detroit, Michigan

Monday, June 6, 2022

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(Proceedings in progress at 11:24 a.m., all parties present, jury present)

MR. HELMS: Yes, Your Honor. Our next witness is Dr. Hersh Patel and he's here now.

THE COURT: Okay. Very good. How are you today?

THE WITNESS: Fine. How are you?

THE COURT: Good. Raise your right hand.

H E R S H P A T E L

was called as a witness herein, and after being first duly sworn to tell the truth and nothing but the truth, testified on his oath as follows:

THE WITNESS: Yes.

THE COURT: Okay. Good. Have a seat. Try to be comfortable in that black chair. Take your mask off.

THE WITNESS: Sure.

THE COURT: And then you can speak toward the mic so it picks you up. Don't get too close.

Mr. Helms, go right ahead.

DIRECT EXAMINATION

BY MR. HELMS:

Q. Good morning, Dr. Patel.

A. Good morning.

Q. Could you please state your full name for the record?
A. My name is Hersh Patel.
Q. Are you a former employee of the Pain Center?
A. Yes.
Q. Before we get to that, let's talk about your background. What is your educational background?
A. So I -- I'm -- I -- I -- I'm a doctor, physician by training, and I did my specialty in anesthesiology after med school and then a subspecialty in pain management.
Q. When did you graduate from med school?
A. I graduated in 2013.
Q. And immediately after med school what did you do?
A. I did an intern year at Hahnemann University Hospital in internal medicine for one year.
Q. And -- and next?
A. And then after that I did an anesthesiology residency for three years at New York University.
Q. And in your last year of residency what was your title?
A. I was the chief resident at that time.
Q. What does it mean to be chief resident?
A. The chief resident is selected amongst our peers as the one that showed I guess like the most leadership attributes and then also someone that showed a lot of ability to do -- perform the work as an anesthesiologist the best amongst the class.
Q. And how many people were in your class in New York

University?
A. Twenty-two per class, so 66 total.
Q. Okay. After your year as chief residence, what did you do -- chief resident, what did you do?
A. I did a fellowship in pain medicine at New York University.
Q. And how long was that?
A. That was one year.
Q. And approximately when did that end?
A. That ended in 2018.
Q. Do you have any board certifications?
A. Yes. I'm double board certified in anesthesiology and Pain Medicine by the American Board of Anesthesiology.
Q. Are you involved with any medical -- medical societies in Delaware that are particularly relevant?
A. I'm currently part of the Medical Society of Delaware and serve on multiple boards and committees with them.
Q. What's your primary role in that society?
A. So I'm -- I'm chair of one committee and a member of multiple committees, providing recommendations specifically along the lines of pain management in the state because that's my specialty, and helping -- helping Medical Society of Delaware give its recommendations for the state on recommendations about any sort of pain management legislation.
Q. Are you currently employed?

A. Yes.
Q. Where?
A. At ChristianaCare which is a hospital system in Delaware.
THE COURT REPORTER: I'm sorry, at where?
THE WITNESS: ChristianaCare.
THE COURT REPORTER: Okay. Thank you.
Q. How large is ChristianaCare?
A. ChristianaCare, it's -- well, it serves 80 percent of the Delaware population. It spans all throughout Delaware and then we just took over hospital systems in Maryland and may be taking over some hospitals in Pennsylvania.
Q. What is your current position at ChristianaCare?
A. I'm currently the section chief which means that I direct both the inpatient and outpatient programs for pain management there.
Q. And what would be your primary responsibilities as section chief?
A. So my primary responsibility is creating the operations and policies around pain management for the entire hospital system and then coordinating care for all the patients that require any sort of pain services in the hospital setting and then in the outpatient setting.
Q. And as section chief do you have any role in observing doctors?
A. Yes. So I'm also in charge of credentialing for the

hospital system, and because we serve such a large population of Delaware, I credential almost all the pain providers that are in our state, and so I have -- I have the responsibility of monitoring the different pain practices that are in the state that are private and approving their credentialing with our hospital.

Q. Let's move now to your initial contact with the Pain Center. How did you hear about the Pain Center?

A. I heard about the Pain Center through a recruiter.

Q. And why were you looking for a job in Michigan?

A. So my wife is a psychiatrist. She was finishing up her residency at Henry Ford Hospital here in Michigan and we were about to have our first child. Initially I was actually going to be opening up a private practice in New Jersey, but because of our newborn, I decided I wanted to come to Michigan and be with the family, so I contacted the recruiter who got me in touch with the Pain Center.

Q. Do you send a resumé to the recruiter?

A. I did.

Q. And then what happened?

A. The resumé was sent to Dr. Bothra and the -- we -- we set up a time to have a phone conversation. He was interested in pursuing my employment there, and so we decided we would have a time that we got together and discuss the -- the -- the position and kind of what the employment opportunity looked

like in person.
Q. And did you go to visit in person?
A. I did. So one of the -- I believe it was in November of 2017 I ended up going there on a Saturday on one of his procedure days and I ended up observing him, observing the procedures and just learning more about the position.
Q. And what location were you at?
A. I was at the Warren site.
Q. Okay. And how did that meeting go with Dr. Bothra or Bothra?
A. So I mean overall, like, I felt that he -- he was providing -- he was giving me an opportunity to practice pain the way I wanted to and that I would be an independent contractor being able to make decisions the way I wanted and providing interventional pain care at that site.

I think a big question for me was always about the -- well, what are the -- are we going to be prescribing opioids, and the answer was always just that we're going to be -- we -- we don't do much, we do the minimal amount.

And kind of like when we kind of went through the office, the office setting and all that, there was -- there wasn't much there, so I didn't really have much to base my decision off of besides the interaction that I had with Dr. Bothra and the four or five cases that I went in with him on.
Q. After that meeting did Dr. Bothra ask you for references?

A. Yes.
Q. Who did you use as references?
A. I asked Dr. Letison [sic] who's an anesthesiologist, Dr. Gharibo who is the Medical Director of Pain at that time and --
Q. Do you recall a Dr. Michael Wajda?
A. Oh, Dr. Wajda. Yeah, he was our Program Director for Anesthesiology.
Q. Were you close with Dr. Gharibo?
A. Yes. He was my mentor and continues to be my mentor even now.
Q. What happened after you provided references?
A. After I had my -- after I give those references, I received an email with terms for the contract and we started negotiating what that contract would look like.
Q. And did you ultimately sign a contract?
A. I did end up signing that contract sometime in December.
Q. There should be a binder near you with Exhibit 154. Actually, I can come help you.

(Brief pause)

Dr. Patel, do you recognize Exhibit 154?
A. Yes, this was the contract that I signed.
Q. And do you know when you signed it?
A. I think it was sometime in December of 2017.
Q. If you look in the beginning, maybe the first paragraph, there's an effective date. Do you see that?

A. February 14th of 2018.

MR. HELMS: Your Honor, at this time I would move Exhibit -- Exhibit 154 into evidence.

THE COURT: Okay. That's received. Go right ahead.

MR. HELMS: Ms. Adams, we don't need to bring it up just yet.

BY MR. HELMS:

Q. Dr. Patel, what was your title under the contract?

A. I was an independent contractor, Exclusive Employee Independent Contractor.

Q. Okay. And we'll discuss this more later, but once you started, did you feel like you were an independent contractor?

A. No. A lot of the -- the problem is like the -- the way that it was -- the oper -- the way that everything was structured, you were either -- you either did what was there already or you just weren't following -- you -- you -- there -- there was no time or ability to make any sort of independent medical decisions.

Q. What time or what date did the contract specify would be your first official day?

A. July 16th, 2018.

Q. And how were you to be compensated under the agreement?

A. So I was given a base salary and then a percentage of collections based off of the procedures I did and the amount of patients I saw.

Q. What were the bonuses that you would receive for various procedures?
A. Um, the -- for procedures it was 80 percent of collections unless it was auto related, then it was 40, and then for office visits I think it was 40 percent, but none of this included the ancillary services.
Q. You -- you did or did not -- you were or not going to receive bonuses for ancillary services under the contract?
A. I was not receiving bonuses for ancillary services.
Q. And what was your understanding of what ancillary services were?
A. So they were urine drug screens, durable medical equipment, physical therapy, chiropractic care, so the things that I was told Dr. Bothra was make -- was able to make his money off of.
Q. Well, yeah. So did Dr. -- did Dr. Bothra ever tell you specifically who benefitted financially from the ancillary services?
A. Yes.
Q. And who was that person?
A. Dr. Bothra.
Q. Okay. Under Section 10F of the agreement, how much notice did you need to provide before you submitted any resignation?
A. I had to give a 90-day notice after my resig -- after to be able to resign from that position.

Q. Okay. Let's turn now to when you started at the Pain Center. Did you have an unofficial start before your official start date of July 16th, 2016?
A. Yeah, I actually volunteered to come in the week before. I mean this was my first job out of fellowship. I actually wanted to have ownership over it and really provide quality care and understand the system before I started treating my first patient, so I ended up going to the clinic a couple days before my start date.
Q. Was that the week before?
A. The week before.
Q. And who -- did you shadow any doctors at the Pain Center?
A. Yeah. At that time I shadowed Dr. Edu, Dr. Bothra and Dr. Lewis.
Q. Was Dr. Edu the first doctor you shadowed?
A. Yes.
Q. What happened while you shadowed Dr. Edu?
A. Um, so I mean I was kind of thrown off by it, but we saw quite a few patients over a short period of time and he had a very structured questioning mechanism that he had, and every patient received some sort of narcotic script and there was no physical examination that was done which really threw me off or -- yeah. And so --
Q. And what -- with respect to those visits, what about -- you said there's no physical examination. What kind of

questions would Dr. -- or questions or information would Dr. Edu provide regarding opioids?

A. So -- and there -- there was no discussion about the safety or efficacy of the medication or talking about whether it's helping, whether it's -- you know, what the risks are of taking this medication or what's going to happen if they take this long term. There was -- there was no discussion about the opioids itself; it was just a script that was given.

Q. And during that time shadowing Dr. Edu did you notice anything about the -- the EMR system or the medical records system in place?

A. Yeah, so the medical -- the EMR system that was being used was kind of like a checkbox, and so as long as you hit enough of the checkboxes, it filled up the -- the -- the -- the document or like the actual progress note enough so that it looked like there was a lot being done, but in reality none of that was really being done.

Q. Did Dr. -- did Dr. Edu ask questions of his patients about whether they had prior conservative treatments like physical therapy?

A. No.

Q. Did he say anything about how many patients each doctor at the Pain Center saw in a day?

A. He mentioned -- he mentioned during my time there that -- that -- that they were seeing up to 80 patients a day at times.

I don't remember him giving an exact range.
Q. Okay. What was your initial reaction to what you were observing with Dr. Edu?
A. I mean initially I was just kind of -- I thought, you know, why -- how is this possible, like why -- like this can't be the reality of things, and I -- I really just thought that this was causing so much patient harm unwittingly but it's -- it was being done, and it felt like it was almost like a factory that was created just to make a lot of money and not really help anyone.
Q. Did you bring any of your concerns during that first unofficial week to Dr. Bothra?
A. Yes.
Q. What did you tell him?
A. I asked about the prescribing habits and the decision making that was going on, and I mean each time I was just told that this isn't an academic practice. This demographic, this isn't how you treat this population or this demographic, they require a different way of treatment.
Q. Were you satisfied with his response?
A. No. I felt even more frustrated afterwards.
Q. Did you shadow anyone else during that first unofficial week?
A. I shadowed Dr. Lewis as well.
Q. Okay. And did you -- did you shadow Dr. Bothra for any

procedures?
A. Yes.
Q. Okay. Was there anything that stands out to you with respect to the procedures that Dr. Bothra did during that first unofficial week?
A. So I think the biggest thing that stood out to me was the -- well, first the sterility factor. All the syringes were being made early in the morning with no sterility involved. They were using the same vial to draw on multiple syringes, keeping the syringes completely open, using the same gloves, just dumping them onto a basket that had labels just saying this -- this is for SNRB, this is for local. And the medications were just the same medication for each syringe, no thought about like, you know, if this patient has some sort of medical history like diabetes or something, are we going to be using the steroid, are we not.

And then when the procedure was actually being done, most of the time I was kind of shocked at like there -- there was no safety mechanisms being used like contrast injection to see if there's any intravascular --

THE COURT REPORTER: Doctor, I have to ask you to slow down.

THE WITNESS: Sorry about that.

THE COURT REPORTER: "...to see if there's any intravascular..."

A. To see if there's any sort of intravascular injection, so into the arteries or veins, to prevent things like stroke from happening. And the needles were being placed way outside of where I would expect them to be placed, and so I wasn't sure how we were calling it the procedure that it was actually being -- that -- said being done.

Q. What about with the patient visits you saw with Dr. Lewis, was anything concerning there?

A. So same thing with Dr. Lewis, I mean the pace of the procedures being done and the inaccuracy of the injections. Most of it just seemed like they were trying to get the needles in just enough so that -- or just to the right spot so that it looks almost okay on imaging, but in reality they were missing the target by centimeters.

Q. Did you witness any patients express hesitancy to Dr. Lewis about receiving injections?

A. Yes.

Q. And how did Dr. Lewis respond to that?

A. So anytime there was any sort of hesitancy about getting an injection done, the patient would be told we're going to start cutting -- you're going to have your meds cut down or that you need to go for surgery, or most of the time it was just you're going -- your meds are going to be taken away.

Q. Still in that first unofficial week, did you happen to notice when doctors would fill out forms like procedure notes?

A. Yes. So when -- when the procedures were being -- before the procedure was done, there was an entire -- there was a wall full of procedure notes and they were already kind of prefilled with whatever information they would need for billing. And so they would grab a sheet a even before they went to go do the procedure, they would fill it out, put the pre- and post-pain scores and go do the procedure and come back.

I think the biggest problem I saw with that was that a lot of what we do as interventional pain physicians is we're trying to figure out is this intervention helping the patient, and the fact was that they were making up these numbers and there was no one doing an assessment of whether or not these procedures were actually helping or hurting.

Q. And you said they. Who specifically did you see do that?

A. I saw Dr. Bothra, Dr. Lewis, Dr. Edu.

Q. Other than the things we've mentioned, did you see anything else that concerned you during that first shadow week?

A. Overall, I mean I think it's just the urine kind of being everywhere, that was something that kind of threw me off a lot. There was vials of urine, bags and bags of urine just kind of collected all over the space. Didn't understand why there -- there needed to be so much urine collection. The goodie bag of things that they were kind of giving out to every new patient. Why did every new patient need a back brace, an ice pack and, you know, the -- the -- the -- the bag in general. It seemed

like it was -- sorry.
Q. Go ahead, you can finish your answer.
A. It just seemed like it was like a billing thing or like they were just trying to bill for extra.
Q. Did you ask any of the doctors about these things that you saw?
A. I did.
Q. And what would they tell you?
A. That this is just how it's done and that this is how we --
MR. COLLINS: Your Honor, he needs to specify, all due respect, who he's speaking with.
THE COURT: I would agree.
BY MR. HELMS:
Q. Did you ask any of the defendants at the tables here about these issues?
A. Yes. I spoke to Dr. Edu about it, and I mean the response was usually that this -- this is how -- this is the -- this is what we do to help the patients. This is also how we get -- how -- this is how we say thank you to Dr. Bothra or like kind of give back to what -- you know, because he gave so much to us.
Q. Can -- can you elaborate on that? What do you mean that he said, "This is what -- how we say thank you"?
A. As in a lot of what -- the -- the money that they were making off of was based off of the procedures and the -- the

patients that they were seeing. So Dr. Bothra was getting most of his revenue from the ancillary services, so the physical therapy, the urine drug screens, the durable medical equipment or the back braces, things like that, and so to support him, this was kind of what they did.

Q. Specifically, with respect to the prescriptions that you were seeing -- you were seeing being issued, was there anything concerning there?

A. So for me it was -- I think the thing that threw me off the most was the age of patients receiving some of these narcotics. I mean to see a 20-year-old go through back injections and get medications was kind of just -- you know, it -- it's a whole life that's being destroyed.

But outside of that, it was kind of the way that the medications were just being handed to the patient without any sort of discussion about alternatives or any sort of risks, benefits, things like that.

I think those are kind of the two big things that bother me.

Q. So during this first unofficial week when you're seeing these things, did you do anything?

A. I -- I -- I brought up my concerns with a few people, but I also started kind of fearing my own future. I mean this was my first job outside of fellowship and I -- I -- I felt like I was getting involved with something that I didn't find to be

ethical, and so I actually brought a recorder and started recording conversations.

Q. Before we get to that, did you contact anyone outside of the Pain Center about what you were seeing?

A. Yeah, so I did contact a few peers, I went to some colleagues that graduated before me, kind of see how their practices were, talked to them about is this normal.

THE COURT REPORTER: Doctor, I really need you to slow down please.

THE WITNESS: Sorry about that.

Q. And Dr. Patel, just I'm asking you -- I'm going to be asking you who you reached out to. I don't want you to tell me what they said, okay?

A. Okay.

Q. Okay.

A. I reached out to colleagues, I reached out to mentors like Dr. Gharibo and also reached out to the DEA.

Q. After you talked to Dr. Gharibo and your -- your other people you reached out to, how did you feel about the concerns you had been having?

A. I felt like I was validated.

Q. So you then contacted the DEA?

A. Yes.

Q. How did you contact the DEA?

A. I found a phone number online and had a phone

conversation, and then I was asked to email all that information directly to them.
Q. And did you do that?
A. Yes.
Q. And was this before your official start on July 16th, 2018?
A. Yes.
Q. Okay. And then over that weekend before your official start, did you do anything?
A. Yeah. I got my -- I got a recorder.
Q. And whose idea was it for you to record people?
A. My own.
Q. Had you discussed that with any federal agency before you started doing it?
A. No.
Q. Okay. And why did you decide that you were going to record people?
A. Because I wanted to protect myself and make sure that if something did come about with all of the unethical things that we were seeing, I wanted to make sure that I -- I -- I had some sort of support showing that I was trying to do the right thing here.
Q. Let's move to your first official day on July 16th, 2018. In general, what did you do that day?
A. So that day I did some shadowing and then saw some new

patients.
Q. And who did you shadow?
A. I was shadowing Dr. -- I believe it was Dr. Lewis.
Q. Did you record your interactions in the shadowing with Dr. Lewis?
A. Yes.
Q. Before that day, did you know who you were going to be shadowing?
A. No.
Q. Okay. We're going to get into some of those recordings in a moment, but in general, what did you learn from Dr. Lewis on that first day shadowing?
A. Basically that visits were two to three minutes tops and that there was a one-size-fits-all for every patient and that the end goal was to get procedures, get ancillary services in trade for some medication.
Q. And did Dr. Lewis have any discussion with you about the importance of billing for ancillary services?
A. Yes.
Q. What would -- what did he say about that?
A. He said that that's how we give back to Dr. Bothra.
Q. Dr. Patel, in the binder, and I'll come over there too, you should have an Exhibit 163, well, a page tab for 163.
A. Mm-hmm.
Q. Dr. Patel, on -- on your first day you -- you recorded

interactions with Dr. Lewis and others, correct?
A. Yes.
Q. Okay. And you've reviewed that -- you've listened to that recording before today?
A. Yes.
Q. And do you know approximately how long that recording is?
A. It's probably around nine to ten hours.
Q. Okay. And have you also listened to clips and excerpts taken from that recording?
A. Yes.
Q. And is Exhibit 163 that entire recording?
A. Yes.

MR. HELMS: Your Honor, at this time I would move Exhibit 163 into evidence.

THE COURT: Received. Go right ahead.

BY MR. HELMS:
Q. Between seeing patients on that first day with Dr. Lewis, would he talk to you about the Pain Center in general and give you advice?
A. Yes.

MR. HELMS: Ms. Adams, could we play clip 163A-1?

(Audio recording being played)

BY MR. HELMS:
Q. Dr. Patel, what did you understand Dr. Lewis to be telling you on that day?

A. That this was going to be a very fast-paced clinic, that we see high volumes, and you kind of just have to keep chugging to get through.

MR. HELMS: Ms. Adams, can we play clip 163A-3?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, what was your reaction to that -- those comments that day?

A. So I think for me, it was -- I was thrown off by the fact that we're not really looking to actually provide any sort of medical care. It sounded like we were just trying to get documentation, like we're just trying to get some numbers down, get information in so that we could get our billables. And so I think for me it was a lot of introspection about why -- why are we even acting like doctors here and like that -- that that kind of shows, you know, that -- that -- that -- that model of -- I would say like a McDonald's drive-thru that they had going.

Q. During that clip at one point you said, "That's awesome." Was that how you were feeling in the moment?

A. No. I was actually just trying to figure out how I'm going to get out -- out of there most of the time. And at the end of the day, like, I was surrounded by people that believed that what they were doing was not causing any harm, and as a new fellow I -- I didn't have a voice there and I think that

scared me the most, so I was just going with whatever conversations that were coming up.

MR. HELMS: Ms. Adams, can we play clip 163A-4 next and -- and stop at around the 58-second mark?

(Audio recording being played)

You can stop it there, Ms. Adams.

BY MR. HELMS:

Q. Could you explain to the jury, Dr. Patel, what you understood Dr. Lewis to be telling you about office code visits there?

A. So he was saying that even if when we -- when he goes to see the patient and information isn't captured, he'll -- as long as the EMR record can show that things were done, like a physical examination or a history taking, then you could still -- that he still bills for that higher code for better reimbursement. So even if nothing was done in the room itself, as long as it was documented as if it was done, it should be billed at a higher code or it would be billed as a higher code.

Q. So were the patient file notes actually commensurate in scope with what Dr. Lewis actually did in the visits?

A. No. So for the most part, I mean I -- the -- the visits really consisted of going in there, talking about what injection was going to be done next, saying refills, talking about the refill. And then I -- there was some -- there were sometimes where he would go through some of the pain symptoms,

talking about where is it located, does it go down the legs, things like that, but that was pretty much it.

MR. HELMS: Ms. Adams, can we play next 163A-5?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, what was Dr. Lewis saying here about the Pain Center patients?

A. I mean -- I mean sounds like he was saying that most of them are abusers of the medication and that if we give them access to something that can be abused, they will abuse it. And I -- I guess the -- there -- he -- he's pretty much saying like that demographic or the population that they treat are mostly just people suffering from some sort of drug addiction.

Q. Did you have a reaction to that at the time?

A. I mean I felt that it was -- it was kind of horrifying that a clinic that should be a behavioral health clinic helping these patients recover from their life of addiction and suffering, getting them back to a safer community is being, you know, hosted by a group of guys that are pretty much just doing a bunch of injections and giving out medications, so I was -- that -- that -- it was really frustrating to hear that.

MR. HELMS: Ms. Adams, could you play clip 163A-28 and start around the 50-second mark?

(Audio recording being played)

You can stop it there, Ms. Adams.

BY MR. HELMS:
Q. Dr. Patel, how did Dr. Lewis's comments about patients here coincide with how he treated his patients in office visits?
A. I mean I think it kind of explains a lot. The -- the SLS, I mean shitty life syndrome, is something that shouldn't be taken lightly. I think that is something that people suffer from on a day-to-day basis and they don't get the right support. And I think when we're -- you know, the -- if we're feeding them narcotics, that that's only worsening their entire life situation. But, yeah, I mean it kind of reflects on how he treated the patients in the room too, don't give them the time -- sorry.
Q. How would he treat patients in the room?
A. Didn't give them the time to talk. Didn't give them time to explain their story. Didn't give them options on how to actually recover from these traumas and injuries and their shitty life syndrome.
MR. HELMS: Ms. Adams, can we play clip 163A-7?
(Audio recording being played)
BY MR. HELMS:
Q. Dr. Patel, what was Dr. Lewis saying there to you?
A. That you kind of just -- he was making up documentation for the sake of documenting for these auto cases. And I guess like the second part to it was that the auto cases were being

shifted over to Dr. Bothra mostly.
Q. Do you know why the auto cases were being shifted to -- shifted over to Dr. Bothra?
A. Because they reimburse a lot more than a standard insurance policy patient.
MR. HELMS: And Ms. Adams, can you next play clip 163A-11? I'll note this has a lot of background noise so it's a little bit harder to hear.
(Audio recording being played)
BY MR. HELMS:
Q. Dr. Patel, I know that was hard to hear, but what -- what was your understanding of what Dr. Lewis was telling you here?
A. It sounded like he was talking about the procedure volumes, that as you increase volume, as -- as you increase the amount of procedures that you do, you'll be able to make a lot more money, and it was just about doing it faster and faster, really no discussion about whether you're actually doing the right thing for the patient or not, but obviously the more procedures we do, the more money we can make.
MR. HELMS: Ms. Adams can you play 163A-12?
(Audio recording being played)
BY MR. HELMS:
Q. What was Dr. Lewis saying here?
A. So he was talking about the ancillary services, the DME, urine, physical therapy, how it -- it makes a lot of money for

Dr. Bothra, and if we're able to increase the cut that we get from the bonuses, that we would get a cut of that piece as well eventually, and the procedure volumes that -- because we do so much volume, you can make a lot of money here.

Q. Now, we've already heard several clips where Dr. Lewis is mentioning money to you and money made off of procedures. Had you done anything to indicate that you were -- had you asked about that or indicated you wanted to know more about that?

A. About the procedures? Sorry.

Q. About the compensation. Had you indicated that you wanted to know about compensation or was that unsolicited?

A. No, I didn't really ask about the compensation.

MR. HELMS: Ms. Adams, can we play clip 163A-18 next?

(Audio recording being played)

BY MR. HELMS:

Q. What did you understand Dr. Lewis to be telling you here?

A. So basically if we started prescribing higher doses of narcotics, we would go under the radar and we could potentially get into trouble because of the system, so to try to stay under the radar, we prescribed lower doses of the medication.

Q. When you said "yeah yeah" in this clip, were you actually agreeing with Dr. Lewis?

A. No, not at all.

Q. What -- what were you actually thinking at the time?

A. At that time I was thinking it's pretty egregious that

we're basically saying that all patients need narcotics. We're not really talking about what we could do to help patients come off of them or give them any of the other support that they need. There was more -- I was just -- again, this was a system that -- a factory that they pretty much created, and I was just a part of it at that point and I didn't have any other -- I didn't have an ear to actually even listen to my concerns. It sounded like everything was just being brushed off.

MR. HELMS: Ms. Adams, can we play clip 163A-20?

(Audio recording being played)

BY MR. HELMS:

Q. So Dr. Patel, can you explain briefly to the jury what you were hearing here?

A. So he's -- we're -- he's discussing two different procedures. One is called a caudal epidural steroid injection and one is a lumbar epidural steroid injection. So both injections are trying to put some sort of solution into what's known as the epidural space, and that's basically when you have pain that goes down the legs.

The problem is that the caudal epidural is a totally different location than the lumbar. Lumbar is considered to be the lower back. Caudal is supposed to be -- is closer to the tailbone area. And so they -- they're generally used to treat different nerve roots.

So the spine's kind of broken up into different

segments, and so underneath the lumbar segment there's sacral. So the sacral nerve roots are the ones that go into the pelvic area, and the lumbar nerve roots are the ones that go down the legs. And so generally a caudal epidural is only used if you're really targeting those sacral nerve roots, so if you have lumbosacral radiculopathy, and not so much for lumbar. And if it is something in the lumbar region, you should be doing what's called a lumbar epidural, but that takes more time.

And so he's making the argument that you should -- that he does caudal epidurals because it's quicker. May not be best for the patient, it may not be needed, but it is quicker.

MR. HELMS: Ms. Adams, can we play clip 163A-29?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, what was Dr. Lewis telling you here?

A. So in this clip we're talking about what's called a radiofrequency ablation, and that's basically where we're trying to burn the nerves that go into the facet joints, and he's talking about specifically how he does the cervical facet joint, RFA.

So it sounds like initially we talked about using motor and sensory stimulation. So the motor and sensory stimulation is a test that we do to make sure that we're not burning off a motor nerve or something that will make us lose

function or cause nerve injury or weakness long term, and so he's claiming that we don't need to do those things.

When we look at the guidelines that were -- that have been out for a very long time, like the -- the sensory part of it, yeah, we don't need much of, but the motor is mandatory. The motor nerve -- motor testing prevents us from having any sort of nerve damage that could cause permanent weakness -- permanent weakness in the lower extremities.

MR. COLLINS: Your Honor, objection as to his opinion.

A. And so --

THE COURT: Well, hold on a minute. I think the latter part of that answer does veer into an opinion, and so I would just ask you to redirect the witness at this time, Mr. Helms. Go right ahead.

MR. HELMS: Yes, Your Honor.

BY MR. HELMS:

Q. Dr. Patel, in the clip you -- you agreed with Dr. Lewis that you don't do motor and sensory testing. Is that actually true?

A. No.

Q. So in your practice what do you do?

A. We do motor testing on all patients and that's to prevent any sort of nerve injury.

MR. HELMS: Ms. Adams, can we play clip 163A-32 and

start around the 37-second mark?

(Audio recording being played)

BY MR. HELMS:

Q. So Dr. Patel, what was Dr. Lewis saying here?

A. So he was saying that in his previous position he was making around 275,000, but now with this opportunity, because of the amount of volume that they see, that he's able to make a lot more.

Q. Did you ever have any similar discussions with Dr. Bothra or Dr. Edu?

A. Yes, with both.

Q. What would they say?

A. They would say that I have an opportunity to make millions here and that if -- if I just continue to practice and do what they're doing, I -- I could be making a lot of money as well.

MR. HELMS: Your Honor, I just checked the time. I'm going to be moving into some videos or recordings or patient visits. Should I stop here or...

THE COURT: I think now would be a good time for a lunch break. It's 12:21. We can take a 40- or 45-minute break, be back at 1:00, go till 4:00 and call it a good day, okay?

Ladies and gentlemen, enjoy your lunch. Feel free to walk outside and relax if you want. Don't talk about the case while you're on your break and we'll see you in about

45 minutes.

Let's all rise for our jurors now.

(Jurors excused at 12:22 p.m.)

You can step down, Doctor. Thank you.

(Witness excused at 12:22 p.m.)

THE LAW CLERK: The Court is now in recess.

(Court in recess at 12:22 p.m.)

(Proceedings resumed at 1:07 p.m., all parties present)

THE LAW CLERK: All rise for the jury. The Court is back in session.

(Jury entered the courtroom at 1:19 p.m.)

THE COURT: Okay. Everybody is in their spots and we may all be seated.

Back to work with Mr. Helms examining Dr. Patel. Go right ahead.

BY MR. HELMS:

Q. Dr. Patel, we're going to move now to some clips of recordings you made with patient visits at the Pain Center while you were shadowing Dr. Lewis, okay?

A. (Nods in the affirmative.)

MR. HELMS: Ms. Adams, can we pull up 163A-23?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, do you know if this was a new patient or an

established patient visit?
A. This is a new patient visit.
Q. Did you have any concerns about this visit?
A. So I think the biggest concern was that there was no questions about any of the medical history, anything that she's tried in the past to help with the pain outside of the pain medications. There was no discussion about what the actual symptoms were and trying to rule out other issues that could be causing the pain that she's experiencing, and just the -- the brevity of the visit, like not getting enough information out of it, no physical examination and just kind of throwing out these ancillary services without giving options, just saying you have to use our physical therapy, our chiropractor and going on with it.
Q. Now, wouldn't the medical assistants at the Pain Center do a -- a medical history with the patient before they saw the doctor?
A. They generally write down the history, the medical and surgical history of the painter, yes.
Q. So isn't it okay for you just to rely on that?
A. No. So the -- the -- as a physician, you're making clinical decisions --
MR. COLLINS: Again, Your Honor, objection as to opinion.
MR. HELMS: Your Honor, I was asking as to his

practice, not --

THE COURT: Let's limit it to --

MR. COLLINS: He doesn't have a practice.

THE COURT: Well, I think he can limit it to how he was practicing with these patient write-ups at the Pain Center when he worked there and how he relied on them. That's what we should limit the testimony to.

Go ahead, Doctor, if you would please.

THE WITNESS: So when I was there I would do a full evaluation for the patient and actually find out if the medical history was accurate or not because there was a lot of pieces that were generally missing that a medical assistant isn't trained to get that information from the patient with. So like -- and a lot of the -- the clinical findings would lead to my decision making, and so it was really important to make sure I was doing the physical exam to find the actual source of the pain because even if they have back pain, that didn't mean that it was coming from the back necessarily. It could be a knee issue causing the gait instability, it could be a hip pathology causing the back pain, things of that sort.

BY MR. HELMS:

Q. How did this visit compare to all of the other new patient visits that you -- you shadowed Dr. Lewis on?

A. This was pretty typical of -- actually it almost felt like he was asking more questions than usual, but this is typical of

the type of new patient consultation he had.

MR. HELMS: Ms. Adams, can we pull up 163A-15?

(Audio recording being played)

Ms. Adams, can we also play clip 163A-16, which is shortly after this visit?

MS. ADAMS: I'm sorry, what did you say?

MR. HELMS: 163A-16.

(Audio recording being played)

MR. HELMS: You can stop it there, Ms. Adams. Can you stop it there?

BY MR. HELMS:

Q. Dr. Patel, anything concerning to you when you were witnessing this visit?

A. I mean the first thing that stands out is I guess the way that he's interrupting the -- the patient from actually explaining what she's experiencing and what's happening. The C-section is probably one of the most important things to hear out because the fact that she has a baby, she might be breast feeding, so there's no followup questions about that. If she's taking a narcotic, it's going into the baby's bloodstream, could potentially go into the breast milk. So it's something that you want to avoid in patients like this.

MR. HELMS: Ms. Adams, can you play clip 163A-33 and start it around the 28-second mark?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, anything about this visit that was concerning to you?

A. I mean it continues on like that kind of structured, every -- every patient fits one size picture. And I think one of the things that really concerns me is that the patient is already diverting medication or like taking medication from his mother, and yet we're still prescribing him medication even though he's using someone else's controlled substances, and there's no question asked about that or concern.

Q. I'm going to move now to some established patient visits that you observed Dr. Lewis on.

MR. HELMS: Ms. Adams, can we play clip 163A-2?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, did you have any concerns about this patient visit?

A. It was very quick. There was no assessment done about whether or not the narcotics that he was about to prescribe were actually being used appropriately or if he had any medications left over. It was just a script being given. And the whole conversation was just about the next procedure, and it almost felt like he was leading the patient to talk about the procedure that he wanted rather than asking about what's actually happening with the patient.

MR. COLLINS: Objection as to how it felt to him, Your Honor, his opinion.

THE COURT: I think it's acceptable for him to characterize his view of how he evaluated the conversation.

Go ahead, Mr. Helms.

BY MR. HELMS:

Q. Dr. Patel, how did this office visit compare to other established patient visits that you have observed Dr. Lewis on?

A. This was typical of almost all the followups.

MR. HELMS: Ms. Adams, can we play 163A-19?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, how would you have reacted to this patient's mention of swelling from an injection?

A. Well, so considering the timeline and the fact that the second injection didn't work, I would be concerned that maybe the needle placement wasn't appropriate or there was a complication from the procedure, and so I would probably do a full assessment, at least a physical exam to see why that swelling is happening. And if there is concerns that it's coming from the heart or kidneys, still do somewhat of a workup for her because it is a complaint that happened and it happened recently. So I would definitely be working up to see if this was a complication of the actual procedure.

Q. Okay.

MR. HELMS: Your Honor, the next clip we're going to play is 163A-35, and there's a couple portions we're going to skip through just because it's the -- the patient is with a father, the patient is the father, his son is interpreting for him, and so there's some foreign language discussion that we'll just skip through.

THE COURT: Okay.

MR. HELMS: So Ms. Adams, can we pull up 163A-35?

(Audio recording being played)

Can we skip to 2:03 here Ms. Adams?

(Audio recording being played)

Skip to 4:55 now, Ms. Adams.

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, any concerns about this visit?

A. So the first thing that caught my attention was about the injection: if he didn't get the injections, they would start taking away his medications.

And I think the -- the other part to it that concerned me was the patient brought up a concern, and the concern, rather than being addressed, was being dismissed. Whenever a procedure is discussed, you're always supposed to talk about the risks and adverse effects or the risks and benefits of the procedure, and it seemed like none of that was being discussed. In fact, it was just said that there are no

complications or there are no issues with getting these procedures. So it felt like it was very misleading for the patient.

Q. Was this the only time you heard Dr. Lewis tell a patient that if he didn't get injections, his medication would be cut?

A. No, that was -- sorry.

Q. How often would you hear that?

A. I -- I heard it pretty frequently.

Q. On your second day at the Pain Center, July 17th, 2018, did you record any interactions that day?

A. Yes.

Q. And if you take a look in your binder at Exhibit 164.

A. Yeah.

Q. Did you review the recording associated with Exhibit 164?

A. Yes.

Q. And what is Exhibit 164?

A. A conversation with Dr. Edu and a patient, patients.

Q. Recordings from July 17th, 2018?

A. Correct.

Q. Do -- do you recall approximately how long that recording was in its totality?

A. I would say it was a few hours. I'm not exactly sure though.

Q. Okay.

MR. HELMS: Your Honor, this time I would move

Exhibit 164 into evidence.

THE COURT: Okay. 164 is received. Go right ahead.

BY MR. HELMS:

Q. Dr. Patel, did you record any office visits with Dr. Edu on that day?

A. Yes.

MR. HELMS: Ms. Adams, can we play clip 164A-4?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, did you have any concerns about this visit?

A. Yeah. So the only information that we gathered was that there was a pain score and that she had some response to an injection, but there was no other conversation about where her pain was, what the actual response of the injection was or treatment or what's happening with the actual medications that she's taking, and it was a very short visit.

Q. How did this visit compare to other patient visits that you shadowed Dr. Edu on?

A. This is pretty typical.

Q. Approximately how many visits did you shadow Dr. Edu on?

A. I would say around 10.

Q. How often would Dr. Edu do physical examinations?

A. I saw it on one patient.

Q. How often would he discuss opioid risks with -- with patients?

A. None.
Q. How often would he consider nonopioid medication?
A. None.
Q. How -- how often would Dr. Edu recommend injections?
A. With most of the patients that he saw.
Q. Now, moving from that first official week until your time overall at the Pain Center, did you get a sense that the -- the visits that you shadowed Drs. Bothra and Lewis and Edu on were similar to how they continued to practice while you were there?
A. I actually felt like they were shorter as I wasn't shadowing. I almost felt that there was --
MR. COLLINS: Object, Your Honor, as to foundation.
MR. HELMS: That was going to be my next foundation, Your Honor. I could do it first if you like.
THE COURT: Yep.
MR. HELMS: Okay.
THE COURT: If you'd clear that up, go ahead.
BY MR. HELMS:
Q. Dr. Patel, where in -- on the clinic side, where was your office in comparison to Drs. Bothra Edu and Lewis?
A. We didn't have an office but we had a workspace, and that workspace was in the middle of all the exam rooms that were on both sides of that workspace.
Q. And how close together were those exam rooms?
A. Very close with not much in terms of insulation or sound

barrier.
Q. What were you able -- were you able to hear anything in the other exam rooms while exams were going on?
A. Yes.
Q. Okay. And so based on that, did you get an understanding of how much time Drs. Edu, Bothra and Lewis would spend on the patients?
A. Well, that was one indication. The other thing was while I'm writing one note, a lot of the other providers would have seen two, three, four at a time during that short time period.
Q. Okay. So the visits that you continued to overhear, how do they compare to the ones the jury's heard today?
A. The ones that I overheard would -- I -- some of them would be actually a lot more aggressive, more angry, more direct, and then they would just be generally either shorter if it was just for medications and then I would say there -- there was more emotion.
Q. Did you come to have any concerns about the patient volume being seen at the Pain Center?
A. The -- so I think the volume in general, I mean, yes, there's a huge concern for the volume.
Q. Did you try to do anything to address it?
A. Yes. I -- I requested to cap the amount of procedures that I had to do and the patients that I saw. I requested -- I told Mimoza who was the manager for the clinical side that I

did not want any walk-in patients.
Q. Do you know if Dr. Bothra was informed about your request to cap your procedures?
A. Yes.
Q. And how did he respond?
A. He said it's fine to start with and then I'll learn and I'll work my way up to what everyone else is doing because that's how you make the money.
Q. And so when you say work your way up to what every -- everyone else was doing, do you know what that was, what -- what Dr. Bothra indicated that was?
A. Seeing 60 to 80 patients a day.
Q. Okay. Did Dr. Bothra ever say anything to you about the patient -- specifically about the patient population as to why you needed to see a certain number of patients?
A. So the argument was that the demographic -- this is what the -- this is what the population needed and this is how they had to be treated because of their insurance but no other real explanation about why.
Q. I believe you said during your first week you had some concerns about the -- the procedures for the injections and the -- the sterility surrounding those, is that right?
A. Yes.
Q. Do you come to have any other concerns about injections as your time went on at the Pain Center?

A. So I'd say the sterility, the inconsistency in technique and the volume. I'd say it was also the amount of anesthesia that was being administered, so every patient received anesthesia and they almost seemed overly sedated for the case. And unfortunately the -- the way that we do assessments for these procedures, we're assessing pain, but when a patient is deeply sedated, how do you assess whether or not they got pain relief or if it's just the anesthesia overly sedating them? So that was a big confounding factor.

And then I was also concerned about how much reversal agent we needed to wake these patients back up after going under anesthesia. So the safety issue there is that if the patient is too sedated and they have some sort of injury from the procedure, more like a nerve injury or something, they're not able to respond. They're not going to even know that they had that injury until a day or so later once the anesthesia wears off.

Q. You mentioned at the beginning of that answer the inaccuracy involved. Did any particular doctors that you noticed, were they inaccurate more so than others?

A. When shadowing Dr. Bothra I did feel like he -- he -- he was -- he was missing the target a lot more than the other provides.

Q. Are there any risks associated with injections when they're -- when they're rushed or placed in the wrong place?

A. There's -- there's always a risk of obviously injuring a nerve or having an infection at a site that you really shouldn't have an infection at or might not be so controllable. There's the risk that it'll cause more muscle damage and more long-term pain at the end of the day, especially with ablations when you're burning tissue. If you're burning the wrong tissue, it could lead to more weakness, more pain, more dysfunction long term.

Q. Moving to facet injections, are those diagnostic or therapeutic or both?

A. So they're generally -- they could be done either as a diagnostic or therapeutic, so both.

Q. Could you explain that to the jury?

A. So with the facet joints, there's two nerves that go into these joints, and when we do these blocks --

MR. WEISS: Excuse me. I would object.

THE WITNESS: Sorry.

MR. WEISS: This witness has been presented as a fact witness and now he's going into opinion. Not only did we not get a Rule 16 disclosure, but the Sixth Circuit has frowned upon one witness being both fact and opinion.

THE COURT: Okay. Well, if a witness is not testifying as an expert, which I don't think this witness is, he can speak about opinions that are rationally related to his perception, things that are helpful to the jury's understanding

of facts that he's testifying to and other things that are not based on science. So I think he's discussing his perception of his job and explaining to the jury his understanding of -- of what a facet joint injection is and I think that's permissible. So overrule the objection.

Go ahead, Mr. Helms.

MR. WEISS: Thank you, Your Honor.

BY MR. HELMS:

Q. So you were explaining that they can be for diagnostic and therapeutic, correct?

A. Yes. So there's two nerves that go into these joints. When we're doing a diagnostic block, we're putting local anesthetic there to see how much relief the patient actually gets, with the intent that we're going to burn those nerves with the radio frequency ablation down the line if it's successful, if it provides at least an X amount of -- a certain percentage of relief of the pain. In a therapeutic block we're providing the injection with the intention that it'll give at least three months of relief with that one injection. And that's kind of how we break up those two, so either/or can be done.

Q. So with respect to the doctors that you observed or overhear, Drs. Bothra Edu and Lewis, what did they do to evaluate the effectiveness of the first injection?

A. So there generally wasn't any evaluation. The -- the

notes were generally filled out before the procedure was done. So it was actually the -- the medical assistant would be doing the workup, have -- bring the patient in, the procedure would be done by the provider and then back to the MA, so there really actually wasn't any assessment being done.

Q. Did you ever hear Dr. Bothra tell patients that they had to get injections in order to get pain medication?

A. Yes.

Q. How would you hear that?

A. Generally from the -- the angry conversations he would have leaving the rooms right next to where we were -- where our work stations were.

Q. During your time at the Pain Center would you see patients that had previously been seen by the defendants?

A. Yes. So one of the -- sorry.

Q. That's okay. So with respect to those patients, did you ever ask them if the injections they were receiving were helping?

A. I -- I did, yes.

Q. Okay. To some patients, every patient, how many patients would you ask that to?

A. I would ask it to all the patients.

Q. And what would they say?

A. So for the most part, they would say that the injections weren't working and that they needed to get the injections done

for their medication.
Q. Are you able to estimate how many people told you the injections weren't helping?
A. I would say close to 75 percent, 80 percent.
Q. Did you record any -- any of your -- your visits with patients during your four months at the Pain Center?
A. Yes.
Q. And why did you record those visits?
A. I was actually just recording it to -- because I felt like I needed to have my -- protect kind of my work being done as well, like to come -- if anything came about, I just wanted to have some sort of record there available.
Q. And in those -- in the two office visits you recorded, did the patients make any statements about why they were receiving injections?
A. Yes.
Q. And if you look at Exhibit 165 in your binder, do you see what's listed there?
A. Yes.
Q. Okay. What's listed?
A. It's 165A, document for Jones Rena.
Q. Says for patient Rena Jones?
A. Yes.
Q. And that was -- that was a recording that you made?
A. Yes.

Q. And if you look at Exhibit 166, can you tell the jury what that is?
A. 166 is an audio recording of a patient, Marisca Pendarvis. It was an office visit.
Q. And that was a recording you made?
A. Yes.
MR. HELMS: Your Honor, at this time I would move 165 and 166 into evidence.
THE COURT: Okay. 165 and 66 are received, and we've got the transcripts published at the bottom?
MR. HELMS: Yes, Your Honor.
THE COURT: All right. I'll receive 165A and 166A. I want the jurors to know once again that the evidence in the case are the voices on the recordings that you'll hear presumably. The transcripts at the bottom are visual aids to help you but they're not evidence, okay? All right.
Go ahead, Mr. Helms.
MR. HELMS: Ms. Adams, could you play clip 165-A?
(Audio recording being played)
You can stop it there, Ms. Adams.
BY MR. HELMS:
Q. So how often would you hear patients make comments like this?
A. So anytime I would inquire about it, it would come up. And the inquiry was mostly around when I felt like the patient

was having some sort of social struggle, and that's a big part of chronic pain, being able to address or identify when the patient's having problems at home, financially, socially, mentally, all those kinds of things.

MR. HELMS: And can we play clip 166A, Ms. Adams?

(Audio recording being played)

You can stop it there, Ms. Adams.

BY MR. HELMS:

Q. So Dr. Patel, during that clip when you -- I think you asked -- she said the white doctor with glasses. Do you recall that?

A. Yes.

Q. And then what did you ask?

A. Was it Dr. Russo?

Q. And I don't think her answer was verbal. Do you know what she -- how was -- what was her reaction?

A. I don't remember if she nodded or anything.

Q. Okay. Did any of the patients you talked to mention whether Dr. Lewis required injections for pain medication?

A. Yes.

Q. How often would that happen?

A. That was pretty frequently as well.

Q. Okay. Did Dr. Bothra ever give you specific advice regarding caudal epidural injections?

A. Yes. So the advice was that it is a simple procedure

that's a little less painful, and so it helps ease the patient into accepting other procedures like the facet joint blocks which may be a lot more painful for the patient.

Q. Did you have a choice in what steroid to use for your injections?

A. No.

Q. Why not?

A. It was based off of cost. So I remember even with the epidurals when I wanted something that had -- so there's different types of steroids, but the -- the one that they used was one of the cheaper ones like the Triamcinolone which has a black box warning against it for use as an epidural since 2011.

Q. And can you tell the jury what a black box warning means?

A. That means there's a major safety concern about its use and so it's -- it's a warning label that's placed on that medication.

Q. You mentioned earlier sedation concerns and about patients being oversedated, correct?

A. Yes.

Q. Were there any doctors who were known to be prone to oversedating patients?

A. Patients would mention Dr. Lewis and Dr. Russo.

Q. Moving to medications, what prescription was the most common at the Pain Center?

A. Probably Norco.

Q. Do you know what kind of -- was it high or low in terms of dose?
A. So it was pretty set. I mean it was below the 90 morphine equivalents. I would say it's considered median, medium to moderate dosing.
Q. Did the -- did any of the defendants ever have a discussion with you about what opioids to prescribe or not prescribe?
A. Yes.
Q. Who would have discussions with you about that?
A. Dr. Bothra and I've had the discussion with Dr. Lewis.
Q. Let's talk about Dr. Bothra first. What did he tell you?
A. He said they stopped prescribing oxycodone 30 milligrams as soon as there were some cases, and basically it would -- if we -- they -- if we were prescribing high dose opioids, we would be under the radar.
Q. And what did Dr. Lewis tell you?
A. Same thing.
Q. Moving to the back braces, were they sized for each person?
A. No.
Q. Where were they kept?
A. They were kept in a locker in the clinic.
Q. And how many would be in the clinic at one time?
A. There were hundreds in the supply closet at all times.

Q. Were the doctors overseeing the issuance of the back braces?
A. No.
Q. So how would a patient receive a back brace when they came to the Pain Center?
A. It was generally given by a medical assistant. There was a system in place where they -- if the patient had specific insurance and it was covered, the patient automatically received a back brace and the -- there was no fitting, there was no followup, there was no instructions about the back brace given.
Q. Are there any problems that could be caused by back braces?
A. Yeah. So using a back brace long term can actually cause weakness of the muscles and so you actually get worsening pain and more dysfunction long term if you continue to use it and it has to be used appropriately and for short periods of time.
Q. Okay. I want to talk briefly now about the pharmacy that was next to the Pain Center in Warren. Do you recall that pharmacy?
A. Yes.
Q. Okay. Did you know any -- notice anything in particular about that pharmacy?
A. Well, one thing that I found a little strange was that it only -- it had -- it -- it mostly kept the med -- the pain

medications that were being prescribed by the Pain Center in inventory. There really wasn't much else there at the time and -- yeah.

Q. Do you know who owned the pharmacy or the building that it was located in?

A. I'm not exactly sure who owned it. It -- the same --

Q. I don't want you to speculate.

A. Sorry. Okay.

Q. Did you ever see patients doing anything noteworthy outside of the pharmacy?

A. So I've -- I've seen on a couple of occasions where medications would exchange hands outside of the pharmacy. I did see on one occasion a -- a vehicle pull up in the front and where the medication was exchanged there as well.

Q. I'd like to move now to Dr. Russo. Did you ever develop any concerns specific to Dr. Russo?

A. The main concern I had was --

Q. Just yes or no.

A. Oh, sorry. Yes.

Q. Okay. What observations did you have that led you to have concerns about Dr. Russo?

A. When Dr. Russo was giving anesthesia for my cases, a lot of times the -- I would -- I would notice that Dr. Russo was kind of dozing off during a procedure. I mean I felt like it was very dangerous, especially when a patient's under

anesthesia and not being monitored appropriately.
Q. Did you bring this behavior to anyone's attention?
A. Yes.
Q. To who?
A. The clinic manager at that time, I think it was Denisa.
Q. And do you know if she did anything with what you told her?
A. I was told it was brought up to Dr. Bothra.
Q. Okay. But you don't have any firsthand knowledge?
A. No.
Q. Did anything change while you were there with respect to Dr. Russo and whether or not he was dozing off?
A. Not the dozing off, no.
Q. Based on your patient visits, do you know if any of the patients were addicted to pain medication?
A. Yes.
Q. Are you able to estimate approximately how many Pain Center patients were addicted to pain medication?
MR. COLLINS: Objection as to foundation, Your Honor.
THE COURT: I'd agree. We should establish a better foundation for that question.
Mr. Helms, go ahead.
BY MR. HELMS:
Q. Dr. Patel, in all of your years of training, fellowships and residency, were you trained on how to look for substance

abuse?
A. Yes.
Q. And what kind of things were you trained on what to look for?
A. Specifically there was mostly through the XDA licensing program. They teach you about like what to look out for in terms of patient dependency and addiction, so different shading between the two, and addiction is usually when you're not using -- when you're going out of your way to get the medications, either illegally or by other means.

And so the -- to answer the first question, I would say, you know, 30 to 40 percent of the patients had some signs showing -- some signs of addiction.

Q. Okay. What effect did all of the concerns that you had about the Pain Center have on you while you were working there?
A. Sorry, what effect?
Q. Yeah, did it have on you?

MR. COLLINS: Your Honor, objection as to relevancy.

THE COURT: I tend to agree. I think he -- you can answer what he did or...

MR. HELMS: I'll -- I'll move on, Your Honor.

THE COURT: Yeah.

BY MR. HELMS:
Q. Before you resigned from the Pain Center, did you talk to anyone else outside of the Pain Center about what was

happening?
A. Yes.
Q. Okay. And who -- what did you do to -- to talk to somebody?
A. So I reached out to some previous employees of the center. I reached out to some colleagues, mentors.
Q. Okay.
A. Things like that.
Q. And at some point you filed a civil lawsuit, right?
A. Oh, right, yeah.
Q. Okay. A qui tam?
A. Yes.
Q. When did you start looking for an attorney for that?
A. That was the -- close to the third week of -- third or fourth week of being employed there.
Q. Okay. And why were you looking for a civil attorney?
A. The biggest reason was because I thought this was the end of my career. I thought I'm giving in my 90-day notice as a first -- after -- during my first employment. From here on out these guys decide whether I'm going to be able to get credentialing at my next hospital or if I'm going to get a medical license at another state because all that comes from them. And so I -- I -- I wanted something to support my family and I -- I didn't know what else to do at that point.
Q. Do you recall approximately when your qui tam lawsuit was

filed?
A. Somewhere toward the end of August of 2018.
Q. Do you recall when you submitted your resignation to Dr. Bothra?
A. Yeah, August 3rd, 2018.
Q. So you started July 16th. Why did you wait until August 3rd to resign?
A. Well, the number one factor was me, how this being my first job and coming straight out of fellowship, I -- I -- I -- I didn't know if this was going to literally be the end of my career, and so that -- that fear really drove me. But the reason why I ended up doing the resignation was specifically because I saw what harm it was doing to the community and I couldn't stand it.
Q. And when was your last day at the Pain Center, approximately?
A. November 3rd.
Q. 2018?
A. 2018.
Q. And why did you -- why -- why'd you stay until November?
A. Again, because it was part of our contract to have -- give a 90-day notice. And I mean I brought up my concerns with Dr. Bothra multiple times, but it seemed like it -- it -- there was -- there was no response to it.
Q. Did Drs. Edu and Lewis have any response to your

resignation?
A. Their only response was that, you know, the way I practice is more for the academics and it doesn't fit the demographic that they deal with.
Q. Okay. When you submitted your resignation on August 3rd, did you talk to anyone?
A. Dr. Bothra.
Q. Okay. Did you record your conversations that day with him?
A. Yes.
Q. Can you take a look at Exhibit 169?
A. Yes.
Q. Is that the recording from August 3rd, 2018?
A. Yes.
Q. It's your recording?
A. Yes.
Q. Had you reviewed that recording prior to today?
A. Yes.
MR. HELMS: Your Honor, I would move Exhibit 169 in evidence.
THE COURT: Okay. Received. Go ahead.
BY MR. HELMS:
Q. Did you also review some clips from that exhibit prior to today?
A. Yes.

MR. HELMS: Ms. Adams, can we play 169A-1?

(Audio recording being played)

BY MR. HELMS:

Q. So Dr. Patel, in this clip you'd -- you had already told Dr. Bothra you were resigning?

A. Yes.

Q. Okay. And how did he respond?

A. So he said -- he basically was explaining that he was hoping that I would take over or he would kind of have me take on the reins of the practice at some point and that I'm losing out on a lot of money, making millions of dollars a year.

MR. HELMS: And Ms. Adams, can we play clip 169A-2?

(Audio recording being played)

BY MR. HELMS:

Q. This is pretty similar to the last clip we heard, right?

A. Yeah, same type.

Q. Okay.

MR. HELMS: Can we play clip 169A-6?

(Audio recording being played)

BY MR. HELMS:

Q. Dr. Patel, how did you react to these comments at the time?

A. I think the biggest thing that I was feeling then and even before with the prior comments was that, well, where's the patient in all of this? We became healthcare providers to help

people, not to make a ton of money, and no matter how much money you make, it doesn't take away the harm that you're creating. And so every time he said that, that was a reminder of that emotion.

MR. HELMS: No further questions, Your Honor.

(Excerpt concluded at 2:19 p.m.)

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C E R T I F I C A T I O N

I, Linda M. Cavanagh, Official Court Reporter of the United States District Court, Eastern District of Michigan, appointed pursuant to the provisions of Title 28, United States Code, Section 753, do hereby certify that the foregoing pages 1 through 65 comprise a full, true and correct transcript of the excerpt of proceedings taken in the matter of United States of America vs. D-1 Rajendra Bothra, D-3 Ganiu Edu, D-4 David Lewis and D-5 Christopher Russo, Case No. 18-20800, on Monday, June 6, 2022.

s/Linda M. Cavanagh
Linda M. Cavanagh, RDR, RMR, CRR, CRC
Federal Official Court Reporter
United States District Court
Eastern District of Michigan

Date: June 12, 2022
Detroit, Michigan